Safeguarding Adult Review

The Case of CM

Executive Summary

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1 INTRODUCTION

1.1. This Safeguarding Adult Review (SAR) was commissioned by the Havering Safeguarding Adults Board in line with its accountability under section 44 of the Care Act 2014.

1.2. The reviewer considered evidence from family members, verbal and written reports from key agencies and practitioners. In addition, a multi-agency learning event was held as well as two meetings consisting of representatives from key agencies.

1.3. The purpose of a SAR is to understand and learn how services can in the future improve the delivery of services for vulnerable adults. The findings of the SAR identified the following themes:

- Complexity of need and coordination of care
- Discharge arrangements
- Communication between agencies and clinical teams
- Frequent attenders at Hospital
- The involvement of the patient and family members

2 BACKGROUND OF THE CASE CM

2.1. CM was 93 years old when he took his own life at his home on October 2017.

2.2. CM and his elderly, frail wife were known to a wide range of hospital and community health and care services because of their longstanding health issues and their need for care and support.

2.3. In the 12 months prior to his death, CM had eight inpatient admissions to hospital through calls to Emergency Services. In the majority of these incidents, the presenting issues were CM's physical problems.

2.4. As well as his chronic physical problems, CM had a diagnosis of depression with episodes going back to when he was in the armed services in the Second World War.

2.5. He disclosed to members of his family and to Health and Social Care professionals his low mood and his wish to end his life. The evidence presented to the review indicated that there were recent incidents of self-harm and others dating back to his time in military service.

2.6. A protective factor for CM in terms of his low mood and providing a reason for living was considered to be the presence of his wife and family. The view was shared by CM himself, his family and health and Social Care professionals.

2.7. Following a fall at home in October 2017, CM was taken to the Emergency Department (ED) by London Ambulance Service (LAS) and subsequently admitted as an inpatient.

2.8. Three days later, CM was discharged from the hospital to go home. In order to

facilitate his discharge home, support services were recommenced, and the family informed of the planned discharge.

2.9. CM's wife had been admitted as an inpatient on the morning of the same day as CM's discharge from hospital. She had been taken by ambulance to the Emergency Department the night previously.

2.10. Following his discharge from hospital, CM lived at home with support from his family and Westminster Care visiting four times daily until his death five days after his discharge.

3 IDENTIFIED ISSUES

Complexity of Need and Coordination of Care

3.1. CM received treatment, care and support from a wide range of health and social care professionals (e.g. doctors, nurses, occupational therapists, physiotherapists, social workers) from services funded and/or managed by the above agencies.

3.2. According to his GP he was prescribed 21 different medications for the above health issues. His family said that CM experienced physical discomfort due to his health issues for which he took non-prescription analgesics occasionally for pain relief.

3.3. At various times over the 12 months preceding his death, CM was seen by mental health practitioners who carried out assessments of his mental state whilst in hospital and in the community. These assessments did not indicate that he met the criteria for an inpatient mental health admission or require services from the North East London Foundation Trust (NELFT) Home Treatment Team.

3.4. CM's admissions into hospital were precipitated by emergency calls, with the primary cause being physical health problems e.g. falls, difficulty breathing. During the course of his admissions he would sometimes refer to his low mood and suicidal thoughts and he also spoke of these to his family and to staff.

3.5. There were some identified risk factors with regard to CM's mental health including:

- A history of depression
- Previous attempts of self harm
- Suicidal thoughts
- Physical health problems and experiencing chronic pain
- Feelings of hopelessness
- Aged over 75 years

3.6. A key message from the Multi-Agency Learning Event was that whilst CM's individual physical and mental health needs were being met, when considered together an alternative, holistic and systemic approach would have been more appropriate.

3.7. With regard to CM, complexity of his needs should have also included an assessment of his inter-dependant relationship with his wife, who was considered to be a protective factor in terms of CM's potential to self-harm.

3.8. CM's increase in hospital emergency call outs and in-patient episodes suggest that

he was finding it increasingly difficult to cope with his own deteriorating physical health and maintain a supportive relationship with his frail, elderly wife. The home environment and living arrangements together with CM's lack of social relationships outside of his family may have been additional contributors to his poor mental health.

3.9. Another significant feature of CM's treatment and care was that there was no single agency and/or professional that held an active overview of CM, who coordinated the support and, where appropriate, could trigger a multi-disciplinary assessment. Consequently, the care and treatment of CM appeared to be reactive to events and not led by the needs of the patient.

3.10. There were positive and effective examples of joint working but these were inconsistent. Furthermore, there was a lack of knowledge as to how concerns could be escalated so that a coordinator of care could be appointed.

3.11. The pressures of working in services that have high levels of demand, and where there are changes to teams and in individual practitioners, make it difficult for staff to get a holistic picture of the needs of patients with multiple co-morbidities such as CM.

3.12. The feedback from the SAR Learning Event was that there was an incomplete understanding of the roles and functions of teams and clinicians. This is fundamental to effective multi-agency and multi-disciplinary working and particularly important when there are changes to staff and organisation structures.

Discharge Arrangements

3.13. In August 2017 CM attended the Emergency Department (ED) accompanying his wife, who had fallen at home. The doctor in the E D reported that CM was suicidal.CM was admitted into Hospital as was his wife. CM's admission was for his own safety as he was felt to be at risk of self-harming if he was on his own at home.

3.14. During this stay as an inpatient, CM was seen by Enhanced Mental Health Liaison Service (EMLHS). He said he was depressed but denied he would self-harm and stated that his wife was a protective factor. He told the ELMHS psychiatrist "he wanted to die naturally".

3.15. JM was discharged on the 15 September 2017 and CM was discharged on the 19 September 2017. However within hours of returning home CM was readmitted to hospital via the ED after a fall in which he suffered head injuries. He is reported to have, on admission to hospital, expressed a wish to die. His wife was also admitted to Hospital on the same day as her husband.

3.16. EMLHS were informed about CM, and he was reviewed on the 27 September 2017 and a risk assessment completed. At the review CM expressed feelings of hopelessness and worthlessness but displayed no suicidal ideation. He was not considered at a high risk of self-harming.

3.17. Following the review, the plan was to inform Older Adults Mental Health Team (OAMHT) on his discharge and await a review by the palliative care team. Both CM and JM were discharged home.

3.18. In October 2017 CM was admitted to the Emergency Receiving Unit (ERU) via the ED following a fall at home. He was seen by Community Treatment Team (CTT) in the ED who noted his frequent attendance due to falls. He was also seen by Frail Older People's Liaison Service (FOPAL), who were unable to complete a functional assessment, but arranged to see him at an outpatients' clinic following his discharge.

3.19. Three days later, CM was considered to be medically fit to be discharged home. The medical discharge summary recorded that CM had mental capacity, had declined a residential home placement and had said that he was not coping at home.

3.20. There were 'no red flags' for CM. As a result he was not seen as 'a complex case' or 'high risk', and therefore the discharge was considered 'a simple restart' of home support services. CM's son, PM, was informed of the plan to discharge his father from hospital.

3.21. The same morning, CM's wife was admitted to ED Observation Ward at QH. Her son PM had accompanied her to ED the previous evening.

3.22. CM was discharged home in the late afternoon whilst JM was on the ED Observation Ward. A referral to EMHLS prior to the decision to discharge CM would have provided an opportunity to consider the robustness of the discharge arrangements in respect of CM's mental health needs and in light of his wife not being at home.

3.23. In October 2017 CM's son, PM, made a request through the Havering Front Door Team for his father to live with him at his LB Havering rented house. This request was in the process of being assessed by Havering Housing and Adult Social Care at the time of CM's admission to hospital and his subsequent discharge home.

3.24. As part of the assessment PM was visited by a Tenancy Support Officer the day before CM's death in October 2017. PM's concern about the response time for a decision to his request was introduced in a formal complaint to the London Borough of Havering which was responded to in January 2018.

Communication between agencies and teams

3.25. The representatives at the SAR Learning Event expressed concerns about the different electronic record management systems currently in use by the key agencies involved in the care and treatment of CM. These IT systems do not facilitate the sharing of information and joint working across agencies and clinical teams. Consequently, there is the potential for important information to be missed by staff, as they are not able to access and view all the relevant assessment plans of colleagues involved in the care and treatment of patients.

3.26. With regard to CM, it meant that health and social care staff were not able to see the whole picture, and this had an impact on their assessments, treatment plans and decision-making.

3.27. Risk assessments on patients are undertaken by the various health and social care teams in accordance with their respective policies and procedures. These risk

assessments are not always shared. With CM there were multiple co-morbidities, and environmental factors to consider when understanding and managing risks and it would have been potentially beneficial for risk assessments to have been shared

Frequent Attenders

3.28. CM attended hospital on 12 occasions following calls to the Emergency Services in the 12 months preceding his death.

3.29. In the context of CM, his pattern of attendances and admissions to Hospital were not picked up as a concern contemporaneously. There was therefore a missed opportunity to understand the significance of this pattern of attendances and the potential impact on the risk to his health and wellbeing.

Involvement of the Family

3.30. CM had some cognitive issues (mild memory loss) but was considered to have mental capacity and able to make decisions about his care and treatment. He was able to articulate his needs and wishes and, according to his family, was quite determined when he had made his mind up on an issue

3.31. CM was supported by his close family members and they visited him when he was an inpatient and at home. There is evidence that services communicated with the family, in particular his wife and son PM, about the plans for CM's care and treatment.

3.32. From the family perspective it would appear that the communication with health and social care services was not always satisfactory. They did not always feel listened to and their opinions valued. CM's grandson, RM, with whom he appears to have had a very close relationship, believed that there had been a significant change in the way his grandfather spoke about ending his life.

3.33. RM believed that his grandfather's statements about suicide were said with more intent in the few months before October 2017. RM said that he expressed his concerns to staff on the hospital ward, although there is no record of these conversations

3.34. Confidentiality is of great importance and the patient's consent to share information, even amongst close family, needs to be carefully considered and the wishes of the patient respected. Listening to the concerns of family and carers is also important in gaining a full picture of the patient's needs and circumstances. The contemporaneous recording of these contacts with the patient, their family and carers is critical in terms of evidencing practice and decision-making.

3.35. From the reports, the extent of CM's consent to share information with his family is not clear, or if his consent was reviewed over time. It is possible that CM would have agreed to more than one family member being informed and involved in his care and support.

Safeguarding Reports

3.36. The daughter of CM received payments from the Direct Payment Scheme to provide care and support for her mother and father at home.

3.37. In May/June 2017 a visiting physiotherapist reported that CM was incontinent of faeces and urinating into a juice bottle and she raised a safeguarding alert. The safeguarding referral was deemed not to meet the criteria for a section 42 Care Act 2014. The response was to reassess the care support needs, which led to an increase of support funded through DP.

3.38. When responding to a 999 call due to CM having fallen at home, Ambulance staff documented that CM appeared unkempt and noted concerns about the sleeping arrangements of CM and JM. A safeguarding referral about this incident was not made in accordance with LAS policies and procedures, and this was the subject of an internal review by LAS.

3.39. In the early hours of 26 August 2017 the LAS responded to a 999 call from LM by dispatching a Fast Response Unit (FRU). The FRU had a nurse on board. They found JM on the floor having fallen. FRU observed that there was medication scattered throughout the property. Whilst on the scene CM stated to the FRU nurse that he wanted to kill himself and that he had attempted this before. CM said he thought that everyone would be better off without him.

3.40. Following the arrival of the ambulance the FRU requested that both JM and CM be conveyed to hospital for further assessments and that a place of safety be provided for CM.

3.41. In September 2017 following another emergency call, the LAS attended the home address responding to a report that CM had fallen.CM had been discharged from hospital 2 ½ hours previously. CM was conveyed to Hospital by ambulance, where he was admitted

3.42. The ambulance staff had found CM and his wife in a cold house. JM was in her bed and had soiled her bed clothing. CM had no access to a bed himself, as he was sleeping in the armchair and had no warm bedding. The ambulance crew reported that the family had not been informed of CM's discharge from hospital. LAS staff reported a safeguarding concern to the LBH and this was investigated by the Joint Assessment and Discharge Service JAD.

3.43. The Section 42 safeguarding investigation focussed on whether the next of kin was notified about CM's discharge from hospital. The investigation concluded that the next of kin, PM had been informed. The investigation did not address the conditions in the home reported by LAS in the safeguarding alert.

3.44. From the above account, there are some serious concerns about how well the safeguarding policies and procedures worked to protect CM and JM. There were actual, potential and possibly missed opportunities for action to be triggered under the multi–agency safeguarding policies and procedures.

3.45. Concerns were raised on separate occasions by his son the physiotherapist and LAS staff about issues of neglect of CM and JM.

3.46. The author was not provided with a full explanation about the outcomes of the

safeguarding referrals that were made. JAD have expressed concern about the quality of the recording on the AIS system regarding the referrals.

3.47. Furthermore, there appears to have been no feedback or sharing of information with the key agencies about the referrals and the outcomes of any process undertaken under the policies and procedures.

3.48. The safeguarding policies have been recently refreshed by the London SAB and will be signed off at the next Executive Board.

4 CONCLUSIONS

4.1. The hurt felt by the family of CM about their loss of a husband, father, and grandfather was fully acknowledged and reflected in the frank, and open responses of agencies and clinicians.

4.2. The process of this SAR in Havering has been very useful in bringing together the agencies and healthcare professionals involved in the care of CM to learn from this tragic event. It has provided an opportunity to reflect upon practice and the systems that are in place to support treatment and care for vulnerable adults.

4.3. The decision taken by an individual to take his or her own life is complicated and very difficult to predict.

4.4. There can be no certainty that even if all recommendations of this SAR were put into action that there would not be another tragic death or indeed CM's death could have been averted.

4.5. The review has identified a number of areas that it is believed would reduce the risk, and it is for the key agencies to ensure that they are put into action. The findings of this SAR review, whilst specific to services in Havering and the response to CM, has challenges that are familiar to other national safeguarding reviews

4.6. Most notably these challenges are:

- Involving and engaging patients/service users and their carers to make their care and treatment more personal;
- Overcoming the barriers to effective communication between practitioners and agencies; and
- Making multi-disciplinary and multi-agency work more effective

These challenges are on-going and cannot be resolved by any single safeguarding review.

4.7. However, a feature of this review was the willingness and vigour with which health and social care staff and their managers reflected on their practice and the role of their team/unit and agency in response to this tragic death.

This aspect of 'professional curiosity' was of course retrospective as it was applied after a serious event had occurred. Whilst positive, it begs the question as to how 'professional curiosity' can be fostered and applied within a work environment with

all its day-to-day pressures and the clinical and administrative demands of the agency.

4.8. Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family, rather than making assumptions or accepting things at face value.

This has been described as the need for practitioners to practice 'respectful uncertainty' – applying critical evaluation to any information they receive and maintaining an open mind.

4.9. In safeguarding, the term 'safe uncertainty' is used to describe an approach that is focused on safety but that takes into account changing information, different perspectives and acknowledges that certainty may not be achievable

4.10. When adults with vulnerabilities come into contact with health and social care professionals, these interactions present crucial opportunities for assessing risk.

4.11. Responding to these opportunities requires the ability to recognise (or see the signs of) vulnerabilities and potential or actual risks of harm; maintain an open stance of professional curiosity (or enquiring more deeply) and understand one's own responsibility and know how to take action.

4.12. Practitioners, however curious, cannot protect adults by working in isolation. Joint and multidisciplinary working is critical in providing holistic, joined up and effective care and treatment for the patient. It is also vital that the arrangements for collaborative working support the practice of professional curiosity to protect and safeguard adults at risk.

SUMMARY OF RECOMMENDATIONS

1. Agencies should consider how best to develop guidance and managerial oversight of cases to ensure that health and social care professionals identify patients with complex needs so that physical and mental health issues can be addressed holistically and systemically.

2. The required competencies for different health and social care staff regarding mental health issues should be identified at both a strategic and individual level.

3. Training for health and social care staff on the mental health competencies appropriate for their role should be provided and wherever possible on a multi-agency basis.

4. Where there are complex needs identified a health and social care professional should be appointed to coordinate the care and support.

5. A multi-agency directory of information of health and social care teams, their roles and responsibilities, access and availability should be developed, distributed and maintained.

6. A multi agency information-sharing event should be scheduled for Safeguarding Week.

7. There should be a review of the guidance on the involvement of EMHLS when the discharge of an in-patient with mental health needs is being planned.

8. Consideration should be given for the development of a protocol for the sharing of risk assessments across agencies.

9. As an interim measure and in the absence of a technological solution consideration should be given for the development of protocols for the key staff to regularly share information and records.

10. A process whereby frequent attenders to ED and inpatient services are identified in 'real time' and interventions proactively planned should be considered.

11. A review of the relevant policies and procedures should take place to ensure that the patient's consent as to whom they want to be involved and informed is regularly reviewed and documented.

12. The regular audit of adult safeguarding practice that takes place across all agencies should be amended to ensure that health and social care practitioners have the appropriate and up to date levels of knowledge and competencies.

13. The concerns highlighted in this report should be cross referenced with the SAR of HM and where appropriate used to inform its findings and recommendations.

14. Multi-agency training that supports health and social care practitioners to develop and utilise their skills of professional curiosity should be developed.